SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Cincinnati Children Hospital Medical Center
3333 Burnet Ave.
Cinti, OH 45229-3026

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X RELAY EXPRESS ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
1-12

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

JAN 12 2004

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number
(Transfer from service label) 7001 2510 0008 6348 9107

PS Form 3811, August 2001 Domestic Return Receipt 102595-02-M-1540